STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING _____ B. WING _____	C 12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	**614 WEST 14TH STREET MARION, IN 46953**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00139192 and IN00140598. This visit was done in conjunction to a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/4/13. This visit was done in conjunction to a PSR to the Investigation of Complaint IN00138654 completed on 11/4/13. Complaint IN00139192 - Substantiated. No Federal deficiencies related to allegation are cited. Complaint IN140598 - Unsubstantiated due to lack of evidence. Survey dates: 12/3-12/5/13 Facility number: 012809 Provider number: 155799 AIM number: 2011265580 Survey team: Shelley Reed, RN TC Angela Selleck, RN Census bed type: SNF: 25 SNF/NF: 5 Residential: 32 Total: 62 Census payor type: Medicare: 18 Medicaid: 4	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. BUILDING _____ B. WING _____	C 12/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARION REHABILITATION AND ASSISTED LIVING CENTER	**614 WEST 14TH STREET MARION, IN 46953**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Other: 40 Total: 62 Sample: 6 Marion Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC in regard to the Investigation of Complaints IN00139192 and IN00140598. Quality review completed by Debora Barth, RN.	F 000		